PROVIDENCE
Hospice

Statement of Revocation of Hospice Benefit

I choose to discontinue the hospice care that is being provided by Providence Hospice and revoke my hospice benefit effective _____.
(date)

By revoking my benefit, I will forfeit any remaining days of Hospice care for the current hospice benefit period. However, should I meet admission criteria, my hospice benefit may be re-elected at any time with a referral by the attending physician and recertification by the hospice provider.

I understand that Health Care benefits that I waived to receive hospice coverage, will be resumed after the effective date of this revocation and that I may need to contact my health plan to coordinate resumption of my benefits.

Medicaid Clients: Present this document with your Medical Assistance Identification Card (MAID) when obtaining medical services until you receive your new card.

_____	_____	_____
Patient name	Signature	Date
_____	_____	_____
Authorized representative	Signature	Date
_____	_____	_____
Hospice representative name	Signature	Date

Note: An individual may not designate an effective date earlier than the date that the revocation is made.